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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended Accusation Against: **SARAH ASH COMBS, M.D.** **3700 10th Avenue, Apt. 3H** **San Diego, CA 92103** **Physician's and Surgeon's Certificate No. A 125860,** Respondent.	Case No. 800-2020-067207 **FIRST AMENDED ACCUSATION**

Complainant alleges:

PARTIES

1. William Prasifka (Complainant) brings this First Amended Accusation solely in his official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about May 22, 2013, the Medical Board issued Physician's and Surgeon's Certificate No. A 125860 to Sarah Ash Combs, M.D. (Respondent). The Physician's and Surgeon's Certificate expired on December 31, 2016, and has not been renewed.

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JURISDICTION

3. This First Amended Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 2220 of the Code states:

> Except as otherwise provided by law, the board may take action against all persons guilty of violating this chapter. . .

5. Section 2227 of the Code states:

> (a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:
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> (1) Have his or her license revoked upon order of the board.
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> (2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.
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> (3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.
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> (4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.
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> (5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.
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> . . .

6. Section 2234 of the Code states:

> The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:
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> . . .
>
> (c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

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(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

. . .

7. Section 2266 of the Code states:

The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct.

8. Section 118 of the Code states:

. . .

(b) The suspension, expiration, or forfeiture by operation of law of a license issued by a board in the department, or its suspension, forfeiture, or cancellation by order of the board or by order of a court of law, or its surrender without the written consent of the board, shall not, during any period in which it may be renewed, restored, reissued, or reinstated, deprive the board of its authority to institute or continue a disciplinary proceeding against the licensee upon any ground provided by law or to enter an order suspending or revoking the license or otherwise taking disciplinary action against the licensee on any such ground.

. . .

COST RECOVERY

9. Section 125.3 of the Code states:

(a) Except as otherwise provided by law, in any order issued in resolution of a disciplinary proceeding before any board within the department or before the Osteopathic Medical Board, upon request of the entity bringing the proceeding, the administrative law judge may direct a licensee found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

(b) In the case of a disciplined licensee that is a corporation or a partnership, the order may be made against the licensed corporate entity or licensed partnership.

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(c) A certified copy of the actual costs, or a good faith estimate of costs where actual costs are not available, signed by the entity bringing the proceeding or its designated representative shall be prima facie evidence of reasonable costs of investigation and prosecution of the case. The costs shall include the amount of investigative and enforcement costs up to the date of the hearing, including, but not limited to, charges imposed by the Attorney General.

(d) The administrative law judge shall make a proposed finding of the amount of reasonable costs of investigation and prosecution of the case when requested pursuant to subdivision (a). The finding of the administrative law judge with regard to costs shall not be reviewable by the board to increase the cost award. The board may reduce or eliminate the cost award, or remand to the administrative law judge if the proposed decision fails to make a finding on costs requested pursuant to subdivision (a).

(e) If an order for recovery of costs is made and timely payment is not made as directed in the board's decision, the board may enforce the order for repayment in any appropriate court. This right of enforcement shall be in addition to any other rights the board may have as to any licensee to pay costs.

(f) In any action for recovery of costs, proof of the board's decision shall be conclusive proof of the validity of the order of payment and the terms for payment.

(g) (1) Except as provided in paragraph (2), the board shall not renew or reinstate the license of any licensee who has failed to pay all of the costs ordered under this section.

(2) Notwithstanding paragraph (1), the board may, in its discretion, conditionally renew or reinstate for a maximum of one year the license of any licensee who demonstrates financial hardship and who enters into a formal agreement with the board to reimburse the board within that one-year period for the unpaid costs.

(h) All costs recovered under this section shall be considered a reimbursement for costs incurred and shall be deposited in the fund of the board recovering the costs to be available upon appropriation by the Legislature.

(i) Nothing in this section shall preclude a board from including the recovery of the costs of investigation and enforcement of a case in any stipulated settlement.

(j) This section does not apply to any board if a specific statutory provision in that board's licensing act provides for recovery of costs in an administrative disciplinary proceeding.

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FIRST CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

10. Respondent has subjected her Physician's and Surgeon's Certificate No. A 125860 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that she committed repeated negligent acts in her care and treatment of Patient A, as more particularly alleged hereinafter:[1]

11. On or about the night of January 6, 2016, Patient A, who was a teenager, presented at the emergency department of Rady Children's Hospital in San Diego, California. According to Patient A's father, Patient A had intentionally ingested seven tablets of Midol and 10 tablets of iron approximately one and a half hours prior to arrival.

12. At the time, Respondent was a board-certified pediatrician and in training for her subspecialty fellowship in pediatric emergency medicine. Respondent provided care and treatment to Patient A, alongside Dr. S.L., her direct supervisor.

13. Upon arrival at the emergency department, Patient A complained of dizziness, nausea, and vomiting. Patient A was ordered ondansetron for her dizziness and nausea at approximately 23:39, followed by a fluid bolus approximately two and a half hours later.

14. Patient A's vital signs were taken, showing a heart rate of 133 beats per minute, which was markedly tachycardic. An EKG also showed a heart rate of 108 beats per minute. However, Patient A's cardiovascular status was noted on the physical exam as follows: "Normal rate, regular rhythm and normal heart sounds."

15. According to the ED Provider Notes, lab tests were to be ordered, including an iron level test. However, on or about January 7, 2016, at approximately 01:55, a ferritin level test was erroneously ordered, not an iron level test.[2] The lab results reported the findings for "Ferritin," which were received at approximately 02:57. According to the lab results, the ferritin test showed

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[1] References to "Patient A" herein are used to protect patient privacy.

[2] Ferritin is a protein that stores iron inside the cells. A ferritin test measures the level of ferritin in the body. Ferritin levels indicate the amount of stored iron, but they do not measure the iron outside of the cells. An iron test, in contrast, measures the amount of iron in the blood. After a suspected overdose of iron, a serum iron level is the most appropriate test to order to assess for acute toxicity.

a level of "8" ng/mL, with a reference range of 6-70 ng/mL. There were no lab results for iron. Nevertheless, the ED Provider Notes stated: "Labs as per below, grossly WNL . . . Iron well below threshold." The Plan and Discharge Instructions further stated: "Your iron level here was normal."

16. At approximately 04:00 on or about January 7, 2016, Patient A complained of additional nausea to the ED nurse. At approximately 04:02, an additional dose of ondansetron was ordered, which was administered at 04:07. Approximately one hour later, Patient A was discharged home, with the last physician re-assessment occurring at approximately 04:12. Prior to discharge, there was no assessment done and no documentation made as to the etiology of Patient A's continuing nausea and whether or not it would persist.

17. Following discharge, Patient A subsequently developed severe abdominal and chest pain and returned to the emergency department later the same day. Patient A's lab results showed a hemoglobin of 11.1 g/dL. Patient A was found to be in fulminant liver failure due to iron overdose and required an emergency liver transplant.

18. On or about January 14, 2021, Respondent was interviewed in connection with the Board's investigation regarding her care and treatment of Patient A. Respondent stated that she intended to order a total body iron test for Patient A, not a ferritin test. When placing the order, Respondent explained that she typed the word "iron" into the electronic medical record system. According to Respondent, the system automatically defaulted to "ferritin" and, as a result, a ferritin test was ordered instead of an iron test. However, the lab test options that appeared on the screen were actually as follows, from top to bottom:

FERRITIN (IRON)

IRON

IRON + TIBC

Despite "IRON" appearing on the screen, the test for iron was not ordered.

19. At her Board interview, Respondent further stated that when she reviewed the labs, the results appeared as either "ferritin paren iron" or "iron paren ferritin." Despite the word "ferritin" appearing on the results, Respondent stated she expected that the results were

measuring what she thought she had ordered (*i.e.*, an iron level), so she "glanced past it, as you often do in the emergency room, [and] saw a normal level . . . ." According to Respondent, she presumed that the result would likely be normal given the amount of iron tablets that Patient A had reportedly ingested.

20. Respondent committed repeated negligent acts in her care and treatment of Patient A, which included, but were not limited to the following:

(i) Respondent failed to order the correct test to assess for acute iron toxicity and she failed to appropriately review and interpret the test results received;

(ii) Respondent failed to properly assess and document the etiology of Patient A's continuing nausea and whether or not the patient's nausea would persist; and

(iii) Respondent failed to properly document Patient A's tachycardia.

SECOND CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Medical Records)

21. Respondent has subjected her Physician's and Surgeon's Certificate No. A 125860 to disciplinary action under sections 2227 and 2234, as defined by section 2266, of the Code, in that she failed to maintain adequate and accurate records regarding her care and treatment of Patient A, as more particularly alleged in paragraphs 10 through 20, above, which are hereby incorporated by reference and re-alleged as if fully set forth herein.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate No. A 125860, issued to Respondent Sarah Ash Combs, M.D.;

2. Revoking, suspending or denying approval of Respondent Sarah Ash Combs, M.D.'s authority to supervise physician assistants, pursuant to section 3527 of the Code, and advanced practice nurses;

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3. Ordering Respondent Sarah Ash Combs, M.D., to pay the Board the costs of the investigation and enforcement of this case, and if placed on probation, the costs of probation monitoring; and

4. Taking such other and further action as deemed necessary and proper.

DATED: MAR 03 2022

WILLIAM PRASIFKA
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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